RESIDENT SUPERVISION HANDBOOK

RESIDENT SUPERVISION

1. Introduction

   a. In a health care system where patient care and health professions training occur together there must be clear delineation of responsibilities to ensure that patient care is provided by qualified practitioners, whether they be trainees or full-time staff. It is recognized that as resident trainees acquire the knowledge and judgement that accrues with experience, they will be allowed the privilege of increasing authority for patient care.
   b. The intent of this handbook is to ensure that patients will be cared for by clinicians that are qualified to deliver that care and that this will be documented appropriately and accurately in the patient record. This is fundamental, both for the provision of excellent patient care on the one hand, and for the provision of excellent education and training for future health care professionals on the other. Moreover, the fact that VHA's medical and surgical care is increasingly being delivered in ambulatory care settings requires that these principles be as germane for those settings as they are for inpatient settings.
   c. The quality of patient care and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinician/educator is appropriate supervision of the trainees as they acquire the skills to practice independently.
   d. Explicit rules have been established by the Health Care Financing Administration (HCFA) that pertain to billing for healthcare services in clinical contexts where graduate medical education takes place. In this regard, the care of patients in VA facilities must be of the same standard as that provided in VA's academically affiliated teaching settings. Accordingly, such policies have been integrated into this document. (Also see Appendix A.)
   e. On the other hand, in academic settings where residency training takes place—particularly in VA facilities-attention must be given to a broader meaning of resident supervision that goes beyond billing issues. This handbook is prepared to provide guidance in this broader context. This document intends to provide direction for the clinician/educators in VA to enuure that the VA patient receives the highest quality care today and that the trainees in the VA are prepared to provide the highest quality care in the future.

2. Purpose

   a. This chapter outlines policy and procedural requirements pertaining to the supervision of residents. Local policy will be established to flilfill the requirements of this chapter and the applicable aecrediting body standards. When possible, the local policy should be consistent with the policies of the affiliated schools or universities.

Department of Veterans Affairs
Veterans Health Administrations
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VHA HANDBOOK 1400.1
Transmittal Sheet
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RESIDENT SUPERVISION

1. **REASON FOR ISSUE**: This Veterans Health Administration (VHA) Handbook outlines the procedural requirements pertaining to the supervision of residents.

2. **SUMMARY OF MAJOR CHANGES:** The Handbook has been rewritten with specific emphasis on:

   a. Levels of supervision required for residents in inpatient, outpatient and long-term care settings; and
   b. Recognition of organizational changes in VHA.

3. **RELATED ISSUES:** VHA Directive 1400 (to be published).

4. **RESPONSIBLE OFFICIALS:** The Chief Academic Affiliations Officer (14) is responsible for the contents of this handbook. Questions may be referred to (202) 273-8946.

5. **RESCISSIONS:** This VHA Handbook rescinds VHA Manual M-2, Part I, Chapter 26.

6. **RE-CERTIFICATION:** This document is scheduled for re-certification on/or before the last working day of March 2005.

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1. PURPOSE

This Veterans Health Administration (VHA) Handbook outlines the procedural requirements for graduate medical education pertaining to the supervision of residents. In addition, this handbook delineates the following:

a. VHA follows the institutional requirements of the Accreditation Council for Graduate Medical Education (ACGME). ACGME states that "[medical] residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience." This process is the underlying educational principle for all graduate medical education, regardless of specialty or discipline.
NOTE: Accreditation bodies for the disciplines of dentistry, optometry and podiatry have similar requirements.

b. Local policy is to be established to fulfill the requirements of this handbook and the applicable accrediting and certifying body standards.
NOTE: When possible, the local policy should be consistent with the policies of the affiliated schools or universities.

c. It should be understood that documentation of patient care that is acceptable for purposes of third-party billing is governed by guidelines that are defined by payers, such as the Health Care Financing Administration (HCFA) or third-party insurers.
NOTE: Policy and procedural requirements pertaining to the supervision of medical students and trainees in other disciplines are addressed in VHA Manual M-8, Part II.

2. BACKGROUND

a. In a health care system where patient care and health professions training occur together there must be a clear delineation of responsibility to ensure that patient care is provided by qualified practitioners, whether they be trainees or full-time staff. It is recognized that as resident trainees acquire the knowledge and judgment that accrues with experience, they will be allowed the privilege of increasing authority for patient care.

b. The intent of this handbook is to ensure that patients will be cared for by clinicians who are qualified to deliver that care and that this care will be documented appropriately and accurately in the patient record. This is fundamental, both for the provision of excellent patient care and for the provision of excellent education and training for future health care professionals. The fact that VHA's medical, surgical and mental health care is increasingly being delivered in ambulatory care settings requires that these principles be as germane for those setlings as they are for inpatient settings.

c. The quality of patient care and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinician educator is appropriate supervision of the residents as they acquire the skills to practice independently.

d. The principles of good training and educational supervision are not likely to change radically over time. Rules governing billing and documentation however, will inevitably evolve. This Handbook from the Office of Academic Affiliations focuses on resident supervision from the educational perspective. Department of Veterans Affairs' (VA) approach to resident supervision requires careful accommodation of both. The experience of many VHA's clinical staffs in non-VHA settings will bring valuable insights to VHA as it continues its focus on appropriate supervision in the context of its academic commitment to residency training, while implementing efforts to meet compliance requirements for third-party billing.

e. Institutional Requirements Of ACOME state that "[medical] residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience." This process is the underlying educational principal for all graduate medical education, regardless of specialty or discipline. Clinician educators involved in this process must understand the implications of this principle and its impact on the patient and the resident.

3. SCOPE

a. Staff practitioners are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of that responsibility requires personal involvement with each patient and each resident who is participating in the care or the patient. Each patient must have a staff practitioner whose name is recorded in the patient record. it is recognized that other staff practitioners may at times be delegated responsibility for the care or the patient and provision of supervision to the residents involved. It is the responsibility of the staff practitioner to be sure that the residents involved in the care of the patient are informed of such delegation and can readily access a staff practitioner at all times.

b. Within the scope of the training program, all residents must function under the supervision of staff practitioners. A responsible Staff practitioner must be immediately available to the resident in person or by telephone or other telecommunication device as appropriate and be able to be present within a reasonable period of time as defined by local policy. Each service will make available "call schedules" that indicate the responsible staff practitioners and how to contact those practitioners.

c. Each training program is constructed to encourage and permit residents to assume increasing levels of responsibility, commensurate with their individual progress in experience, skill, knowledge, and judgment. The determination and documentation of graduated levels of responsibility is outlined in paragraph 6 of this handbook.

d. Each facility must adhere to Current accreditation requirements as set forth by the ACGME, American Dental Association (ADA), American Osteopathic Association (AOA), American Podiatric Medicine Association (APMA), and Council on Optometric Education (COE) for all matters pertaining to the resident training program, including the level of supervision provided. It is also expected that the requirements of the various certifying bodies, such as the pertjnent member boards of the American Board of Medical Specialties (ABMS), Bureau of Osteopathic Specialists (BOS), American Board of Podiatric Surgery (ABPS), and American Board of Podiatric Orthopedics and Primary Podiatric

Medicine (ABPOPPM) will be incorporated into VA training programs and fulfilled through local facility policy to ensure that each successful program graduate will be eligible to sit for a certifying examination.

e. The provisions of this handbook are applicable to all patient care services, including but not limited to, inpatient, outpatient, community and long-term care facilities, and the performance and interpretation of all diagnostic and therapeutic procedures.

f. In order to ensure the quality of patient care and to provide opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that an appropriately privileged practitioner will be available for supervision during clinic hours. Patients followed in more than one clinic will have an identifiable staff practitioner for each clinic. Staff practitioners are responsible for ensuring the coordination of care that is provided to patients.

g. Facilities must ensure that their training programs provide appropriate supervision for all residents, as well as a duty hour schedule and a work environment that is consistent with proper patient care, the educational needs of residents, and the applicable program requirements.

4. DEFINITIONS

a. Resident. The term 'resident' refers to an individual who is engaged in a graduate training program in medicine (which includes all specialties, e.g., internal medicine, surgery, psychiatry, radiology, or nuclear medicine), dentistry, podiatry, or optometry and participates in patient care under the direction of staff practitioners. Such programs must be accredited or certified as appropriate and as described in paragraph 3.e. of this handbook. The term resident includes individuals in approved subspecialty graduate medical education programs who historically have also been referred to as "fellows" by some sponsoring institutions.

b. Graduate Medical Education. Graduate medical education is the process by which clinical and didactic experiences are provided to residents to enable them to acquire those skills, knowledge, and attitudes which are important in the care of patients. The purpose of graduate medical education is to provide an organized and integrated educational program providing guidance and supervision of the resident, facilitating the resident's professional and personal development, and ensuring safe and appropriate care for patients. Graduate medical education programs focus on the development of clinical skills, attitudes, professional competencies, and an acquisition of detailed factual knowledge in a clinical specialty.

c. VA Residency Program Coordinator. In accordance with accrediting and certifying body requirements, appropriately credentialed local VA clinicians will be appointed as VA residency training program coordinators for each residency training program. In affiliated programs, these designations will be made with the concurrence of the sponsoring entity of the residency program. The VA Residency Program Coordinator is responsible for all training program activities within VA, for the quality of the educational experiences provided within VA, and for assuring appropriate resident supervision.

d. Staff Practitioner or VA Practitioner. Staff practitioner or VA practitioner refers to licensed, independent physicians, dentists, podiatrists, and optometrists, regardless of the type of appointment, who have

been creditialed and privileged at VA in accordance with applicable requirements. A staff or VA practitioner must be approved by the sponsoring entity in order to supervise residents. Staff practitioners may provide care and supervision only for those clinical activities for which they are privileged. This term is synonomous with the “Attending Physician” in medicine.

e. Supervision. Supervision refers to the dual responsibility that a staff practitioner has to enhance the knowledge of the resident and to ensure the quality of care delivered to each patient by any resident. Such control is exercised by observation, consultation and direction, and includes the imparting of knowledge, skills, and attitudes by the practitioner to the resident and the assurance that the care is delivered in an appropriate, timely, and effective manner. supervision may be provided in a variety of ways including person-to-person contact with the resident in the presence of the patient, person-to-person contact in the absence of the patient, and through consultation via the telephone or such telecommunication devices as appropriate. If on-site supervision is not available, the staff physician must be able to be present, if needed, within a reasonable period of time as locally defined.

f. Board Certified. Board certified means a diplomate of a specialty board approved by the ABMS or BOS.

g. Board Certifiable. Board certifiable means having completed an approved residency program in which the training, education, and experience would be expected to result in formal acceptance by the appropriate ABMS or BOS specialty board.

5. ROLES AND RESPONSIBILITIES
Resident training occurs in the context of different disciplines and in a variety of appropriately structured clinical settings, including inpatient, outpatient, long-term care, and community settings. Although specific titles for positions within these settings may vary by facility and Veterans Integrated Services Network (VISN), the following functions must be assigned.

a. Chief Academic Affiliations Officer. The Chief Academic Affiliations Officer is responsible for defining policies pertinent to providing graduate medical education to residents in VA medical centers. VISN summary reports are reviewed on an annual basis to ensure consistency across the system and to provide assurance to various oversight agencies that VA is appropriately discharging its responsibility to provide safe patient care and excellent educational opportunities for the nation's future health care practitioners.

b. VISN Director. The V!SN Director is responsible for addressing graduate medical education program needs and obligations in VISN planning and decision-making and making necessary resources available to the respective affiliated medical centers to ensure resident supervision is provided as outlined in this handbook. The VISN Director reviews the VISN’s affiliated medical centers’ annual reports to identify opportunities for improvement or areas that need further review, and prepares a summary report which is submitted to VHA Headquarters.

c. Network Academic Affiliations Officer. The Network Academic Affiliations Officer assists the VISN Director in:

(1) Ensuring educational reeds and obligations are considered in VISN planning and decision-making;

(2) Assisting medical centers in implementing graduate training policies;

(3) Helping coordinate the VISN's educational programs;

(4) Providing liaison with Network educational institutions;

(5) Providing guidance, coordination and assistance to individual medical centers in negotiating their specific affiliation agreements; and

(6) Helping ensure Network-wide educational goals are accomplished and comply with system-wide education policies (e.g., resident supervision).

d. Medical Center Director. The medical center Director is responsible for establishing local policy to fulfill the requirements of this handbook and the applicable accrediting and certifying body requirements. *NOTE: When possible, the local policy should be consistent with the policies of the affiliated schools or universities*.

e. Chief of Staff. The medical center Chief of Staff is responsible for the quality of residency training programs at the VA medical facility and the quality of care provided by staff practitioners and residents. An Associate Chief of Staff for Education or similar position may assist the Chief of Staff in fulfilling these requirements.

f. VA Residency Program Coordinator. The VA Residency Program Coordinator is responsible for ensuring that Staff Practitioners are appropriately fulfilling their responsibilities to provide supervision to residents and that ongoing evaluations of those residents and their supervisors are conducted. The VA Residency Program Coordinator is responsible for assuring that residents function within their assigned graduated level of responsibility. The program coordinator will:

(1) Assess the staff practitioner's discharge of supervisory responsibilities. At a minimum, this includes written evaluations by the residents (see par. 10) and interviews with residents, other practitioners and other members of the health care team.

(2) Structure training programs consistent with the requirements of the accrediting and certifying bodies (as identified in subpar. 3.e.) and the affiliated sponsoring entity.

(3) Arrange for all residents entering their first VA rotation, to participate in an orientation to VA policies, procedures and the role of residents within the VA health care system.

(4) Ensure that residents are provided the opportunity to contribute to discussions in committees, where decisions being made may affect their activities. *NOTE: Facilities are encouraged, to the extent practicable, to include resident representation on appropriate medical center committees.*

g. Residency Program Director or Affiliate Program Director. The Residency Program Director is responsible for the quality of the overall education and training program in a given discipline (i.e., medicine, dentistry, optometry, and podiatry) and for ensuring that the program is in compliance with the policies of the respective accrediting or certifying bodies. The Residency Program Director defines the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform and those for which residents may act in a teaching capacity. *NOTE: In affiliated programs, the Residency Program Director is customarily at the affiliated institution, but may be a VA staff member.*

h. Staff Practitioner or VA Practitioner. The staff practitioner is responsible for, and must be personally involved in, the care provided to individual patients in inpatient and outpatient settings as well as long-term care and community settings. When a resident is involved in the care of the patient, the responsible staff practitioner must continue to maintain a personal involvement in the care of the patient. The staff practitioner is expected to fulfill this responsibility, at a minimum, in the following manner:

(1) The staff practitioner will direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. Medical, surgical or mental health services must be either rendered under the supervision of the staff practitioner or be personally furnished by the staff practitioner. Documentation of this supervision will be by progress notes entered into the record by the staff practitioner or reflected within the resident's progress note at a frequency appropriate to the patient's condition. In all cases where the provision of supervision is reflected within the resident's progress note, the note shall include the name of the staff practitioner with whom the case was discussed as well as summarize the nature of that discussion.

(2) For patients admitted to an inpatient service of the medical center, the staff practitioner must meet the patient early in the course of care (within 24 hours of admission) and personally document, ina progress note, the staff practitioner's findings and concurrence with the resident's initial diagnosis and treatment plan as well as any modifications or additions. The progress note must be properly signed' dated, and dmed. Staffpractitioncrs are expected to be pers~iy involved in the care of the patients assignedtothem in a manner consistent with the clinical needs of the patient and the graduated level of responsibiJi~ty of the trainee. This must be documented by a ~sonal note by the staff p~actitioner or be reflected in the resident's note.

(3) The staff practitioner who is responsible for consultations on each specialty service will either render the consultation or personally supervise the consultation as described in subparagraph 5h(1). The consulting staff practitioner will meet the patient as soon as possible and will remain involved in the consultation process as long as the service is requested by the staff practitioner responsible for the care of the patient.

(4) For outpatients, all new patients to the clinic for which the staff practitioner is responsible should be seen by, or discussed with, the staff practitioner at that initial visit. This must be documented in the chart via a progress note by the staff practitioner or reflected in the resident's note to include the name of the staff practitioner and the nature of the discussion. Return patients should be seen by the staff practitioner with such a frequency as to ensure that the course of treatment is

effective and appropriate. This must be documented in the record via a note by the staff practitioner or reflected in the resident's note. All notes must be signed, dated, and timed.

(5) The staff practitioner, in consultation with the resident, will ensure that discharge, rr transfer, of the patient from an inpatient service of the medical center or clinic as based on the specific circumstances of the patient's diagnoses and therapeutic regimen. This may include specifics on physical activity, medications, diet, functional status, and follow-up plans. At a minimum, evidence of this assurance will be documented by countersignature of the discharge summary or clinic discharge note.

i. Resident. The residents, as individuals, must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside of that scope of service. Each resident is responsible for communicating to the staff practitioner significant issues as they relate to patient care. Such communication must be documented in the record. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible staff practitioner may result in the removal of the resident from VA patient care activities.

6. GRADUATED LEVELS OF RESPONSIBILITY

a. As part of their training program, residents should be given progressive responsibility for the care of the patient. The determination of a resident’s ability to provide care to patients without a supervisor present or act in a teaching capacity will be based on documented evaluation of the resident’s clinical experience, judgment, knowledge, and technical skills. Ultimately, it is the decision of the staff practitioner as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient that is the personal responsibility of the staff practitioner.

b. The Residency Program Director will define the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform and those for which residents may act in a teaching capacity. The assignment of graduated levels of responsibility will be made available to other staff as appropriate. Annually, at the time of promotion, or more frequently as appropriate, this document will be provided to the relevant VA Residency Program Coordinator, Service Chief, and Chief of Staff along with a list of residents assigned to each year or level of training. The Residency Program Director must include a specific statement identifying the evidence on which such an assignment is made and any exceptions for individual residents, as applicable.

7. DOCUMENTATION OF SUPERVISION OF RESIDENTS

a. The medical record must clearly demonstrate the active involvement of the staff practitioner. Documentation requirements for evaluation and management and ongoing care for inpatients and outpatients are outlined in paragraph 5 of this handbook. *NOTE: It should be understood that documentation of patient care that is acceptable for purposes of third-party billing is governed by guidelines that are defined by payers, such as the Health Care Financing Administration (HCFA) or third-party insurers.*

b. Diagnostic or therapeutic procedures require a high level of expertise in their performance and interpretation. Although gaining experience in performing such procedures is an integral part of the education of the resident, such procedures may be performed only by residents who possess the required knowledge, skill, and judgement, and under an appropriate level of supervision by staff practitioners. Examples include operative procedures performed in the operating suite, angiograms, endoscopy, bronchoscopy, and any other procedures where there is need for informed consent (refer to VHA Handbook 1004.1). Staff practitioners will be responsible for authorizing the performance of such procedures, and such procedures should only be performed with the explicit approval of the staff practitioner. *NOTE: Excluded from the requirements of this section are procedures that, although invasive by nature, are considered elements of routine and standard patient care. Examples are intravenous lines, thoracentesis, paracentesis, lumbar puncture, arterial lines, routine radiologic studies, wound debridement, and drainage of superficial abscesses. Supervision for these types of activities are addressed through the requirements identified in paragraphs 5 and 6 of this handbook.*

c. Under the guidance of their respective service chief, staff practitioners will provide appropriate supervision for the patients' evaluation and management decisions and for procedures. For elective or scheduled procedures, the staff practitioner will evaluate the patient and write a pre-procedural note by describing the findings, diagnosis, plan for treatment, and/or choice of specific procedure to be performed.

d. During the performance of such procedures, a staff practitioner will provide an appropriate level of supervision. Determination of this level of supervision is generally left to the discretion of the staff practitioner, within the context of the previously described levels of responsibility assigned to the individual resident involved. This determination is a function of the experience and competence of the resident, and of the complexity of the specific use.

e. The "level" of staff involvement (as defined in the VHA Veterans Health Information Systems and Technology Architecture (VISTA) Surgical Package) will be documented in the computerized surgical log (a part of the VHA VISTA Surgical Package), consistent with the following scale:

(1) Level 1. Staff practitioner is physically present and directly involved in the procedure;

(2) Level 2. Staff practitioner is present and available for consultation; or

(3) Level 3. Staff practitioner is immediately available to the resident for consultation and support via telephone or other telecommunication device, and is available in person in a reasonable period of time, as defined by local policy. The service chief is responsible for periodically reviewing cases done under Level 3 supervision to ensure that such supervision is appropriate.

8. EMERGENCY SITUATIONS

a. An “emergency” is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment of the health of, a patient. In such situations, any resident, assisted by medical center personnel shall, consistent with the informed consent provisions of VHA Handbook 1004.1, be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate staff practitioner will be contacted and apprised of the situation as soon as possible. The resident will document the nature of that discussion in the patient’s record.

b. In emergency situations involving diagnostic or therapeutic procedures with significant risk to the patient, the resident must consult with, and obtain approval from, a staff practitioner who will be available to assist or to advise as appropriate. In such cases, the staff practitioner will determine, based on the circumstances of the case and the resident’s level of experience, whether to be physically present in the dedicated satellite operating room or operating room, or to be available by telephone or other telecommunication device. If circumstances do not permit the staff practitioner to write a pre-procedural note, the resident’s note will include the name of the responsible staff practitioner. The note will indicate that the details of the case, including the proposed procedure, were discussed with, and approved by, the staff practitioner. In such cases, a staff practitioner must see the patient and countersign the resident’s pre-procedural note within 24 hours.

9. PRIVILEGING RESIDENTS AS INDEPENDENT PRACTITIONERS

a. Residents who are appointed outside the scope of their training program (e.g., fee basis) must be licensed, credentialed and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program and must meet the requirements for appointment, and are subject to the provisions contained in VHA Handbook 1100.19, Credentialing and Privileging. Specialty privileges, which are within the scope of the resident’s training program, may not be granted. *NOTE: Refer to paragraph 6 of this handbook for assigning, as appropriate, graduated levels of responsibility for activities within the scope of training.*

b. Physician Residents

(1) Physician residents who are board certified or board certifiable may be privileged as independent practitioners. Privileges sought and granted may only be those delineated within the general category for which the resident is board certified or board certifiable.

(2) For Admitting Officer of the Day/Medical Officer of the Day (AOD/MOD) coverage, VA medical centers will be expected to have an appropriately credentialed and privileged staff physician or board certifiable physician physically present and available in the medical center at all times. The on-site physician supervisor will be promptly available to assist or provide backup AOD/MOD coverage. When supervised by a staff physician or board certifiable physician, a Post Graduate Year (PGY)-3 and above non-board certifiable resident may be credentialed and privileged to provide AOD/MOD coverage. *NOTE: This serves as an additional exception to the Board Certification Requirements for Physicians contained in VHA Supplement, MP-5, Part II, Chapter 2, Appendix 2M and VHA Handbook 1100.19 Credentialing and Privileging.*

(3) In a critical staffing emergency situation, permission to use a PGY-3 and above non-board certifiable resident for sole, unsupervised coverage may be requested from the respective VISN Director. When such an emergency exists, the VISN Director may approve the use of such a resident on a short-term, time-limited basis, when truly exceptional circumstances exist. In these rare instances, the resident will be appropriately credentialed and privileged and an approved provider of Advanced Cardiac Life Support. *NOTE: This is a separate temporary exception and does not supplant the board certification waiver authority, which resides with the Chief Patient Care Services Officer as defined in Board Certification Requirements for Physicians contained in VHA Supplement, MP-5, Part II Chapter 2 Appendix 2M and VHA Handbook 1100.19 Credentialing and Privileging.*

10. EVALUATION OF RESIDENTS AND SUPERVISORS

a. Each resident will be evaluated according to accrediting and certifying body requirements on the basis of clinical judgment, knowledge, technical skills, humanistic qualities, professional attitudes, behavior, and overall ability to manage the care of the patient. Evaluations will occur as indicated by the accrediting or certifying body, at the end of the resident's rotation, or every 6 months, whichever is more frequent. Written evaluations will be discussed with the resident.

b. If at any time a resident's performance or conduct is judged to be detrimental to the care of a patient(s), action will be taken immediately to ensure the safety of the patient(s). For affiliated programs, the VA Residency Program Coordinator will promptly provide written notification to the Residency Program Director or department or division chairperson regarding the resident's unacceptable performance or conduct. Additional actions should be handled as delineated in VA Manual MP 5, Part II, Chapter 9.

c. Annually, each resident rotating through the VA facility will be given the opportunity to complete a confidential written evaluation of staff practitioners and of the quality of the resident's training at the VA facility. Such evaluations will include the adequacy of clinical supervision by the staff practitioner. The evaluations will be reviewed by the VA Residency Program Coordinator, service chief, and medical center leadership to identify areas where improvements can be made. The program coordinator, service chief, and facility leadership will strive to create an atmosphere that assists residents in being comfortable completing evaluations.

d. All written evaluations of residents and staff practitioners will be kept on file by the Residency Program Coordinator or Residency Program Director, in an appropriate location and for the required timeframe according to the guidelines established by the respective ACGME Residency Review Committee or other accrediting and certifying agencies.

11. MONITORING PROCEDURES

a. Medical Centers. Resident training occurs in the context of different disciplines and in a variety of appropriately structured clinical settings, including inpatient, outpatient, long-term care, and community settings. Although specific titles for positions within these settings may vary by facility and VISN, the following functions must be assigned. Where residents are present, the medical center

Director will report annually to the VISN Director on the status of the training programs in that medical center. This includes any action taken by accrediting or certifying bodies, any changes in the status of affiliations, and a specific analysis of resident supervision issues identified by the medical center's monitoring processes.

(1) The VA medical center Director is responsible for ensuring that the facility fulfills all responsibilities identified within this section.

(2) The medical center Chief of Staff is responsible for ensuring that each VA Residency Program coordinator participates in the facility monitoring process. The Chief of Staff and the executive committee (e.g., Clinical Executive Board, Professional Standards Board) will submit an annual report to the facility Director that affirms the oversight exercised by the Chief of Staff and the executive committee. Any problems that are identified will be reported, together with a plan of action for their remedy. At a minimum, the monitoring process will include the following:

(a) A review for compliance with inpatient, outpatient, and long-term care documentation requirements, as part of the clinical pertinence record review.

(b) Monitoring the supervision of diagnostic and therapeutic procedures involving residents to ensure consistency with the graduated levels of supervision as described in paragraph 6.

(c) Monitoring all incidents and risk events with complications to ensure that the appropriate level of supervision occurred.

(d) A review of all accrediting and certifying bodies' concerns and follow-up actions.

(e) A review of residents comments related to their VA experience.

(f) Analysis of events where violations of graduated levels of responsibility may have occurred.

(g) A review of all tort claims involving residents, to determine if there was an appropriate levels of supervision.

b. VISN. The VISN Director will review the annual reports of all facilities in the VISN to identify opportunities for improvement or areas that need further review. The VISN Director will annually prepare a report summarizing the resident training issues in the VISN. VISN reports will be forwarded to the Chief Academic Affiliations Officer.

c. VHA Headquarters. The Chief Network Officers, the Chief Academic Affiliations Officer and the Chief Patient Care Services Officer will review the VISN reports to ensure that the VA is appropriately discharging its responsibility to provide safe and effective patient care as well as excellent educational opportunities for future practitioners. A summary report and appropriate recommendations will be submitted to the Under Secretary for Health through the Deputy Under Secretary for Health.